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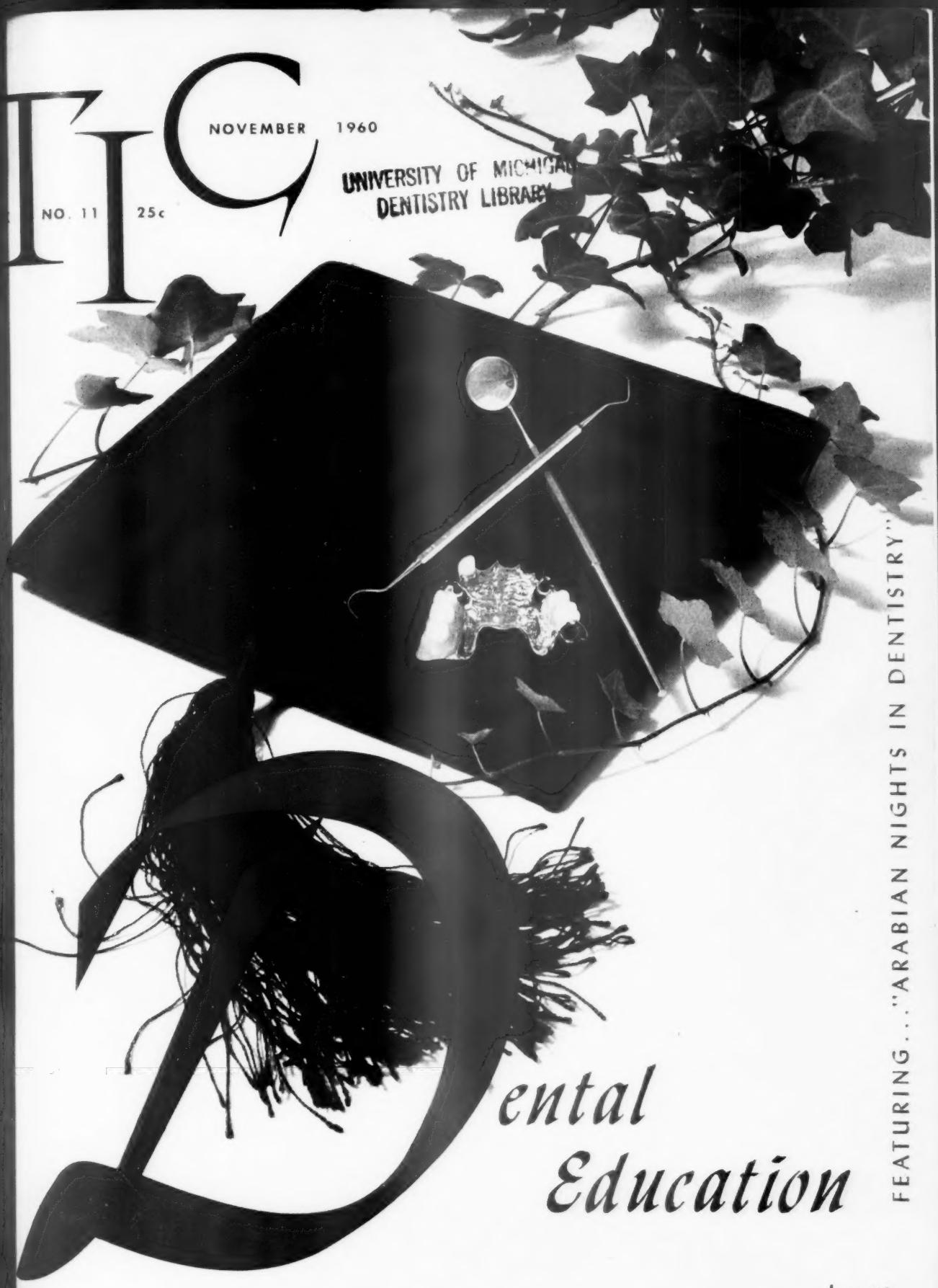

Dental Education

FEATURING..."ARABIAN NIGHTS IN DENTISTRY"

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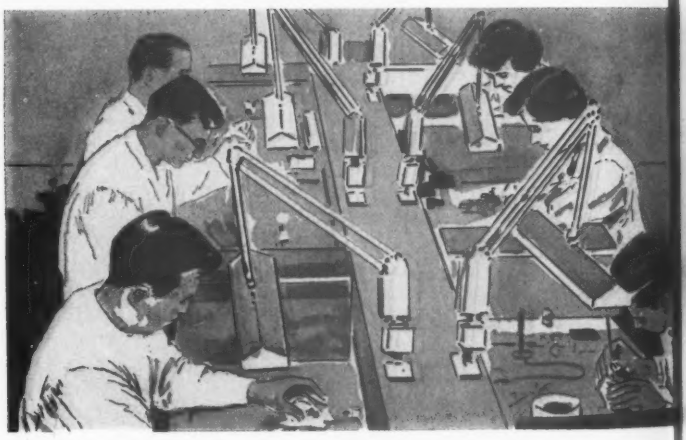

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TIC
A MAGAZINE FOR
DENTISTS
DENTAL HYGIENISTS
DENTAL ASSISTANTS

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November 1960 Vol. XIX No. 11

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PUBLISHED MONTHLY BY TICONIUM
413 N. Pearl St., Albany 1, N. Y.

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TICONIUM DIVISION
CMP INDUSTRIES, INC.
ALBANY, NEW YORK

ANNUAL SUBSCRIPTION, $2.50

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PRINTED IN THE U.S.A. BY
JERSEY PRINTING CO., BAYONNE, N. J.

WORDS TO WIN PATIENTS

By MAURICE J. TEITELBAUM, D.D.S.

To win patients, you must gain their confidence, and that depends, to an extent, on what you say and the way you say it. Semantics may have been overpopularized in recent years into a kind of intellectual parlor game, but in dentistry and medicine "winning words" are often the keys that will unlock the door to success. A highly trained and competent dentist may handle his patients efficiently, yet fail to gain their cooperation and confidence. Patients must not be treated as "broken bicuspids," "retained roots," or "parietal abscesses"—but as people.

Successful professional men have expressed the belief that we are entering an era when scientific therapy and procedures will be taken for granted and that, even more than at present, the ability to handle patients will become the key to a successful medical or dental practice. The insecurities and tensions that beset the world stir the minds and bodies of all of us, and in a society where the cultural centers are being dwarfed by the shopping centers, people find themselves groping for something more than medication and treatment when they are ill. They want explanations, reassurances, and even promises to hang on to, and to keep afloat, in the rising tide of a material world. To do our jobs effectively, we must win the confidence of apprehensive, insecure, and inquisitive human beings. We must sharpen our communicative tools as well as our grinding instruments. The patient asks us: "How will a jacket protect my tooth?" "Why do I need gum treatments?" "Will I have any pain?" We need to be ready to answer in clear, understanding terms. Our answers must not only satisfy the patient's curiosity but they must instill confidence as well.

In talking to many successful dentists, I have compiled a five-step approach in the use of words to win patients.

(1) *Treat the Patient as an Individual.* This has been told to physicians and dentists over and over again, but because it is so important it bears repetition. Speak to your patient as an individual, not as a part of your practice or a set of dentures. Mentioning a mutual acquaintance or a common neighborhood problem, or any simple thing that singles him out from all other patients, is a good beginning. This may seem trite and trivial, but it is an opening wedge. It allows you to get through to the patient more easily. Project yourself, put yourself in his position. Think

of yourself in any similar position confronting a lawyer, an accountant, or a physician—would you want to be treated as just another dentist or as the individual you are, with your particular likes, dislikes, feelings, and attitudes?

(2) *Listen to the Patient.* Very often you can learn as much about a patient's dental problems from his own description of his ills as you can from your examination. Let him explain his difficulties. Listen to his complaints and his interpretation of his discomfort. You will find out how much he really understands about his dental condition and just how much enlightenment he needs. This will give you an opportunity to dispel any faulty conceptions he may have of dental treatment and it will make your explanation of treatment easier for him to comprehend.

(3) *Probe! Probe! Probe!* Don't limit your questions. Get the pertinent data you need that might have a bearing upon the patient's dental health and habits. Recently I planned the construction of six upper anterior crowns for a patient that were to be soldered into a single unit because of the mobility of the laterals. I had planned to construct unit-built copings with porcelain jackets. When the patient returned with the temporary acrylic splint and I removed it to start my impressions, he complained of being very uncomfortable in the area between the centrals. Upon examination I noticed that the tissue there was highly irritated and inflamed. Upon inquiry, the patient told me that he was constantly putting a toothpick between the teeth to enlarge the space. When I asked why, he said that he had the nervous habit of sucking air through his front teeth since he was a child, and that the closing of the space, even for a few days, had made him miserable. I revised my plan and constructed veneer crowns that allowed for more space at the gingival than the unit-built crowns would afford. The patient left the office, when he was completed, happily able to suck air between his front teeth. Admittedly, this was an unusual case, but if I had been more careful in my probing I would have inquired about the presence of any oral habits and avoided the temporary discomfort for the patient. And, if I had put on individual temporary crowns instead of the crowded splint, the patient might not have volunteered the information until the finished bridge was cemented into place and I would have had to remake the case.

(4) *Show You Care.* The most important subject in the world to the patient in your office is his teeth. Most of us take a sincere interest in our patient's dental problems, but do we show it? Or are some of us "cold fish," "too superior," and "too self-centered?" Show you care by using words of encouragement, kindness, and understanding. Give patients your undivided attention during the consultation. This means doing away with distracting influences such as a cluttered desk, an assistant who pops in and out of the office, and unnecessary telephone interruptions.

(5) *Lead the Way.* Very often a patient is offended when a dentist gives the right advice in the wrong way. Most dental treatment, as described by the dentist, deals with procedures that the patient is not happy to hear. However, you must lead the patient to the psychological point at which he will readily accept your advice. This is accomplished by making the patient understand the reason for your plan and by making him feel he has had a hand in making the decision that will affect him. For example, if the patient has anterior teeth that have been in constant need of attention because of recurrent decay, erosion, fractured fillings, and so forth, sympathize with him as to the constant expense and difficulties he has had. Usually the patient will be led to inquire if there is anything that can be done or will he have to lose the teeth. Then you can describe the advantages of the porcelain jacket in his particular case. Invariably, the patient will ask, "Do you think porcelain jackets would be good for my teeth?" He has already understood the need for jackets and the rest is easy.

The successful dentist uses words to win his patients even before he wins them with the caliber of his work. At the chair, too, pleasant, instructive, and friendly words bring cooperation and make working easier and more productive.

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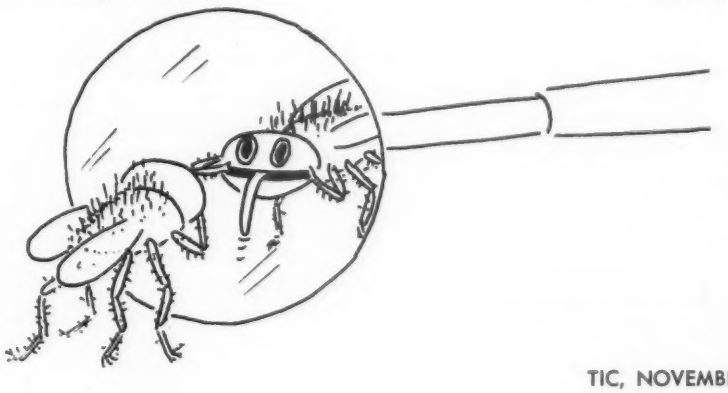
Newark 12, N. J.



By KAY LIPKE WARREN

The Los Angeles County Hospital, rising high against the skyline on the outskirts of the city, is the largest county hospital in the United States.

The University of Southern California Medical School is on its grounds. The University of Southern California Dental School has made use of its vast clinical material by establishing a three-year course in oral surgery, the last two years of which are spent in training within the hospital itself. Distinguished physicians and dentists are on the hospital staff, and many specialists in both professions volunteer their services part time.

Two thousand people a day come for outpatient care alone. The corridors are jammed with stretchers, wheel chairs—long lines of ambulatory sick and injured awaiting treatment. Through open doors, one can glimpse crowded wards. Nurses hurry here and there. Internes pass by, faces intent. Ambulances arrive and depart. Busses from the police department bring in criminal patients.

The hospital's kitchens serve 5,000 meals a day. Its pharmacy is jammed with people waiting for prescriptions to be filled. There is a large branch post office. A separate building houses a telephone exchange. There is an auxiliary electric-generator system, in case a disaster shuts off the regular source of power. It is a city within a city.

On the fourth floor is the Dental Department, presided over by Dr. Paul H. Hamilton. He has been Dental Director of the hospital for 35 years. His assistant, Dr. Ronald H. Sims, has been with the hospital for 22 years. Dentistry in the Los Angeles County Hospital has been a dedicated career, a way of life, for both men.

Dr. Hamilton was on a leave of absence when we visited the hospital, and Dr. Sims was in charge.

"If you stay here long enough," he observed, "you will see everything that can happen to a human being."

That is one reason why the hospital provides valuable clinical material for the teaching of all phases of dentistry, but especially oral surgery. There are over 300 fractures a year alone to be treated in the hospital. The Dental Department has its own beds for its inpatients.

Because oral surgery has progressed so much during the past several years, and must continue to progress, the University of Southern California Dental School in 1954 established a three-year course in oral surgery. Marsh Robinson, M.D., D.D.S., is head of surgery at the School.

This course, approved by the American Board of Oral Surgery, is open to dental school graduates who have passed the California State Board. Out of 30 to 40 applicants each year, two are chosen, they serve the first year of the course at the School, where they are taught office surgery procedure on ambulatory patients, under the direction of Dr. Robinson and other leading oral surgeons.

The second year the two men become junior residents, and the third year senior residents, at the County Hospital, working on an alternating 24-hour schedule. There they do all phases of oral surgery, both minor and major. For three months of each

DR. PAUL H. HAMILTON

DR. RONALD H. SIMS

year they study anesthesia, and run a general anesthesia clinic for children, as well as administer anesthesia for major surgery.

The office shared by Dr. Hamilton and Dr. Sims is small and severely plain by comparison with the spacious, plush dental suites of men in private practice, but Dr. Sims gives one the impression of still being amazed at his good fortune in having the opportunity to spend his entire dental career in this huge institution where professional opportunities and challenges occur around the clock—in County Hospital.

1993 Lucile Avenue
Los Angeles 39, Calif.

General Harlan Named Assistant Surgeon General For Air Force Dental Services

Major General O. K. Niess, USAF Surgeon General, has announced the appointment of Brigadier General Maurice C. Harlan, USAF, DC, as Assistant Surgeon General for Dental Services, USAF. General Harlan succeeds Major General James S. Cathroe, who recently retired.

General Harlan is a native of Rooks County, Kansas. He attended schools in Des Moines, Knoxville and Grinnell, Iowa and received his DDS degree from the State University of Iowa in 1933.

After graduation, he established a dental practice in Knoxville, Iowa and continued in practice until December 1936, when he entered on active duty in the military service. One of his first assignments was as Dental Surgeon of the 1st Armored Division, stationed at Fort Knox, Kentucky. General Harlan served in various other assignments until 1949, at which time he transferred to the Air Force from the Army upon the establishment of the Air Force Medical Service. At this time, he was serving as Chief Clinician and Dental Surgeon of the Valley Forge General Hospital, Penn.

In the early 1950's General Harlan served as Command Dental Surgeon, Alaskan Air Command. From 1952 to 1955, he served at McChord AFB and 25th Air Division, Tacoma, Washington. From 1955 to 1959, he served as Director of the Dental Services Division, Gunter AFB, Alabama.

In June 1959, he was reassigned to the Office of the Surgeon General, USAF as Deputy Assistant Surgeon for Dental Services and was promoted to Brigadier General on 27 August 1960.

General Harlan is a member of the American Dental Association, Federation Dentaire Internationale, Delta Sigma Delta and Sigma Chi fraternities.

General Harlan and his wife, the former Ruth Katter of Garner, Iowa, reside in Washington, D. C. They have two daughters—Teri, wife of Captain P. A. Taylor, USAF, MSC, and Toni, wife of Lieutenant jg A. P. Longton, USN.

WANT TO BE AN ANGEL?

By MARC TYLER

Dentists, like physicians, have earned the well-deserved reputation of being financial investors and plungers. The cash is always greener in the next pasture, so it seems. With the vision of old age ever present; the tapering off of practice income during the less productive years; and without any "business" or "merchandise" to sell when the office doors are finally locked and bolted, most professional men are eager for ways and means of guaranteeing a sizable nest egg.

The purchase of stocks and bonds, mutual funds, real estate, and the role of a "silent" partner in outside business ventures are the ways and means sought by dentists to help swell their bank accounts. Some dentists invest their money individually, others in groups. One such group of investors numbering a dozen men, three of whom are dentists, call themselves the "Goofers." The name, though hardly befitting would-be manipulators of high finance, is nonetheless appropriately descriptive in their case, for with their collective fund they "go fer" anything that promises a good return on their investment.

Many a professional man with a little extra cash on hand has also found himself "going fer" off-beat investments, one of which has been the legitimate theater. Apparently there is something heavenly about being an "angel." In recent years, the Broadway theater, with its long-run shows and "smash hits", has lured many a dentist and physician to the Great White Way, where checkbook in hand, they have rushed in as "angels" where even fools have feared to tread. The glamour that surrounds the theater and the brilliance of the Broadway lights have blinded men into using emotion instead of their reason. For each successful play that means money in the bank for an investor, there are dozens of failures. The odds are too great for a legitimate investment and are stacked against you even for a "flyer." Those in the know, the top producers, often liken their business to horse racing, so great is the risk and so eager is everyone to hit upon a winning system.

The "systems" for picking a Broadway winner exists even among the theater pros and are about as varied as those found among racetrack devotees. For example, some investors like to play the stable owner—that is, they will invest in a play that is being offered by a well-known, successful producer such as David Merrick or Kermit Bloomgarten or Feuer and Martin. Yet, even these topnotch producers have had their share of flops that, during the past few seasons, have meant over a half million dollars in the debit column. Others play the jockey—they feel safe investing in a play with a big star. But there is hardly a big name who hasn't had his or her big bust on Broadway. Many investors prefer to play the horse—they put their money on the playwright, but Williams, Miller, and Inge have had seasons where they, too, finished out of the money. Then there are those who depend on the touts—the friends of friends who have a cousin who knows an electrician who throws the switch in one of the Broadway playhouses. The rest of the investors are hunch players. But no matter what system is used, there is no way to pick a winner without Lady Luck in your corner. For example, the musical *Miss Liberty* had a book by Robert E. Sherwood, music by Irving Berlin, and was directed by Moss Hart. This would have been picked a winner with any system, yet, this musical fiasco never finished the first lap! On the other hand, there was the play *Raisin in the Sun*, by an unknown playwright and with no name stars, that is still bringing in good returns on money invested after its second-year run.

The cost of putting on a Broadway show, particularly a musical, runs about a quarter million dollars. Therefore, the show needs an extended run just to break even, and has to be a smash hit to make money. However, the dentist who is infected with the theater and wants to be a part of the glamour world of make believe, can afford to invest in a Broadway show—for even if he loses money he can always feel that somehow he was able to get into the act!

P.O. Box 350
Albany, N. Y.

A CASH-ONLY PRACTIC

If uncollected bills are a source of "after-hours" concern, a pay-after-each-appointment plan is a practical and proved solution to the problem

By CHARLES FITZ-PATRICK

Could your practice be operated profitably on a cash-only basis?

"Yes indeed!" says a practitioner who speaks from experience. "But it calls for a special kind of courage. You must persevere in your determination to have patients pay after each appointment." He also points out that the policy brings a desirable secondary benefit, the elimination of practically all billing details and bill collecting problems.

This man feels that dental services for cash is a sensible procedure because the amount due following the average appointment is less than $25. "Considerably less in many instances," he claims. "Paying fees of this size on an as-you-go basis is much less painful to the patient that the much higher total resulting from three, four or more appointments."

However, reasoning of this sort is not applied by all dentists to their individual operations. One young dentist claims: "My patients have developed the buy-now-pay-later habit in their general purchases and feel that it should apply also to dental services." But a dentist who has been practicing for a number of years in a suburban area argues that public buying habits do not preclude a cash arrangement in the dental office. "Discount houses and supermarkets are today building high volume, yet they insist on cash payments," he said. He also mentioned that several banks in his section that once offered "revolving credit" plans have abandoned them. "These institutions learned that many persons were extending themselves unnecessarily and the cost of collections had reduced the banks' net from the unique credit idea."

This reference to the cost of credit prompted one dentist to remark that the time spread between the date the dental services are completed and the day the patient clears up his obligation shaves the dentist's net income. "That's because the dentist does not have the money to discount his own bills or deposit in a bank at interest, and if inflation has been at work the dollars eventually collected have less buying power," he explained.

Affect on Practice

The inevitable question, of course, is whether a dentist's insistence on immediate cash payment reduces the number of patients telephoning for appointments. This was answered by a dentist whose office is in a development of homes originally priced in the neighborhood of $12,500. "I started out by requesting payment following each appointment," he said. "No doubt this news got around the area and perhaps slowed down the early growth of my practice. But I'm doing fine now—and without any credit headaches." This man is convinced that success of a dental practice does not hinge on the practitioner's liberality from a credit standpoint, but rather on the quality of his professional services.

The development dentist decided on his plan for some very logical reasons. "Most of my patients," he said, "are members of families paying for homes, appliances, TV, and other possessions on time. This means they must have so much money each month—

or they lose the real estate and merchandise." Since he has seen few television sets going back, he reasoned these individuals were budgeting for general purchases and therefore could be "sold" on the wisdom of anticipating dental fees too. "I'm pretty well convinced it's a matter of proper education," he claimed.

Cost of Credit

One other dentist put his practice on a cash basis because of the advice given him by an older man when he first opened his office. The veteran dentist reminded his young friend that credit carries a variety of costly price tags. He mentioned the earlier specified possible losses—working capital, bank interest, inflation—and then referred to how human nature sometimes acts in a tight money situation. "Very frequently," he said, "a patient who requires additional dental care will switch to another dentist if he is lacking the money to pay your original bill." In such instances the credit-extending dentist may not collect what is due him and may lose as well the future dental work of the patient.

Several dentists who are currently operating as much as practical on a cash arrangement expressed the obvious fact that credit does not eliminate the eventual need for payment. "A patient who claims he will have the money in several weeks or a month," one of these men said, "does not expect to fall heir to a fortune in that time. He simply plans to do some bill juggling and perhaps the dentist's will come up for payment." But there is always the possibility the dentist's bill won't, the dentist said, recalling past experiences.

Like every rule, the cash-following-appointment plan has its exceptions. A dentist who practices in an eastern industrial territory explained his technics. "When a regular patient is faced with an unanticipated dental problem and I know the payday of the family's breadwinner is a week or ten days away, I take care of the patient without question, although I do mention the amount of my fee and that evening I may mail a bill." A similar policy is applied by a dentist whose patient list includes a number of retired persons who receive pension or Social Security checks once a month. If requested to wait, this man does so willingly, although he bills well in advance of the date the patient expects his check so that a record of his fee "will be close to the top of the pile" of bills to be paid.

In those cases where a mouth examination indicates the need for extensive and relatively costly operations, quite a few of the dentists interviewed automatically suggest that the patients finance the charges through a lending company. In fact, one of these dentists said he is partial to this procedure for a very personal reason: "It shifts from me to the financing company the role of 'baddie,' a classification some persons attach to those to whom they owe money." He feels that this also tends to safeguard the good-will he has developed among his patients.

3841 Aspen Street
Philadelphia 4, Pa.

SHIFTING FROM A BILL-LATER TO A PAY-NOW POLICY

Start naming the amount due for services during that appointment as patient steps from the chair.

Have office assistant ask, "Will you pay the doctor's charges now," as patient re-enters reception room.

Advance billing schedule from once or twice a month to within 24 to 48 hours of appointment (s).

Point out to patients the advantages to paying the small sums involved in individual appointments as opposed to larger sums charged for series of treatments.

Start all new patients on a cash only basis.

Suggest a paying policy for current services to those with a record for slowness in meeting their financial obligations.

Doctors Of Dental Surgery

THE STORY OF DENTAL EDUCATIO

HORACE H. HAYDEN, M.D., D.D.S. 1769-1844

THE FIRST DENTAL SCHOOL
IN THE WORLD WAS ESTABLISHED
BY TWO PHYSICIAN-DENTISTS:
HORACE H. HAYDEN, M.D., D.D.S.,
AND CHAPIN A. HARRIS, M.D., D.D.S.
THEY FOUNDED
THE BALTIMORE COLLEGE
OF DENTAL SURGERY

CHAPIN A. HARRIS, M.D., D.D.S., 1806-1860

A hundred years ago the dental scene in the United States was something like this:

Many dental offices were operated by men who had served short apprenticeships with legitimate dentists, had no training or coaching of any kind, or were outright charlatans mulcting the public. Many individuals were practicing dentistry without regard to standards or ethics, and there was no standardization of technics and dental materials. There were no state laws licensing the practice of dentistry, and dental professional organizations were in their infancy. Dentistry was a time-consuming, risky, painful luxury for the patient.

All this has vanished, been done away with primarily by dentists themselves. No profession has accomplished so much in so short a time.

Instead of the brief apprenticeships of those early days, today dentistry offers a lifelong program of professional education and training for all dentists.

A prospective dental student must have at least two years of college education before he can be admitted to a dental school. (About half of the students have the full four years.) He must pass a series of aptitude tests that demonstrate he is fit, by temperament, character, intelligence, digital dexterity, and motivation, to study dentisty. He must successfully complete four years of study and in a qualified, accredited school of dentistry. Finally, upon receiving his degree of doctor of dental surgery, or doctor of dental medicine, he must undergo examinations, by the dental examination board of his own state, that will probe and evaluate his practical and theoretical knowledge of his profession and demonstrate whether or not he is ready to practice dentistry.

And Dental Medicine

ARABIAN NIGHTS IN DENTISTRY

BOOK ONE: CHAPTER XI

THIS is not the end of the modern-day dentist's professional education and training. It continues all through his lifetime, as long as he practices dentistry. Interest in advanced education programs for practice in special areas of dentistry is increasing steadily. There are more than 3,000 specialists who are partially or fully limiting their practices to one of the following recognized areas of practice: oral surgery, oral pathology, orthodontics, pedodontics, prosthodontics, or dental public health. That means more study, sufficient postgraduate training to qualify for a certificate of specialization from one of the boards that evaluate such advanced professional education and experience. In addition, more than half of the dentists in active practice enroll in other courses and special clinics, enter hospital teaching programs for internship residency training, or otherwise expand their professional knowledge and training and keep up-to-date on the many fast-moving developments in dental education, practice, and research.

Today the dental student studies anatomy and oral anatomy, oral surgery, medicine and the principles of medicine, bacteriology, bio-chemistry, anesthesia, general and oral pathology, physiology, diagnosis, pharmacology and materia medica, hygiene, histology and embryology, ethics, jurisprudence, operative dentistry, roentgenology, history of dentistry, public health, dentistry for children, fixed and removable prostheses, plup canal therapy, periodontics, orthodontics, dental materials, and practice management.

He will obtain this wide-scaled, full-dimensioned professional training in one of 47 dental schools accredited by the Council on Dental Education of the American Dental Association. None are operated for profit, and nearly all are associated with universities. Many are affiliated with teaching hospitals. The leadership of United States dental schools and educators is unquestioned throughout the world, and the present high standards of dental education maintained in the United States schools are second to none.

Not only dentists, but dental hygienists and dental laboratory technicians as well, have benefited from first quality educational programs inspected and accredited by the Council on Dental Education of the American Dental Association. Never before in the history of the dental profession in the United States have dentists, hygienists, and laboratory technicians been so well qualified by education, training, aptitude, and experience for the important health services they perform.

Today there are more than 94,000 dentist-members of the American Dental Association, affiliated with 54 state and territorial dental societies, which are made up of 450 district and local units. All these professional groups are devoted to the fundamental task of improving oral health in America through continual research and study which constantly improve the level of dental practice everywhere in the United States.

American dentists, through their professional societies, have moved dental science and dental research forward at an amazing pace. They have led the way to greater know-how and improved procedures for the prevention and control of dental disease. They are devising and encouraging the development of programs that will make available the benefits of dental health to every group in the population. They have made the education and training of dentists in the United States today subject to the disciplines of the nation's great universities—unexcelled anywhere.

That is why the American people are being served by the best-trained, best-qualified, and most skilled dentists in the world.

DENTAL CARE—volume of visits

Adapted from a report prepared by Jane W. Bergsten, of the U. S. National Health Survey staff.

SELECTED FINDINGS

During the two-year period July 1957-June 1959, people of the United States made approximately 517 million dental visits, representing an estimate of 258 million visits per year. This amounted to an average of 1.5 dental visits per person per year.

The rates of dental visits varied greatly among the different subgroups of the population. Members of families having an annual income of less than $2,000 made an average of 0.7 dental visits per year as compared with a rate of 2.5 visits for those in families with an income of $7,000 or more. Similar differences were found among the different educational groups. Where the head of the family had completed at least one year of college, family members averaged 2.4 dental visits per person per year, a rate four times that found for persons in families where the family head had less than 5 years of formal schooling.

In addition, the U. S. National Health Survey data revealed striking differences in rates of dental visits among the different residence and regional groups of the Nation.

People living "inside urbanized areas," which

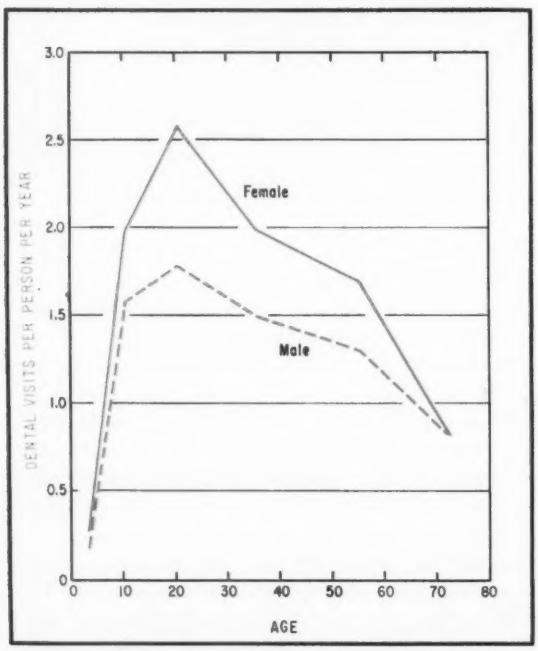


Figure 1. Number of dental visits per person per year by sex and age.

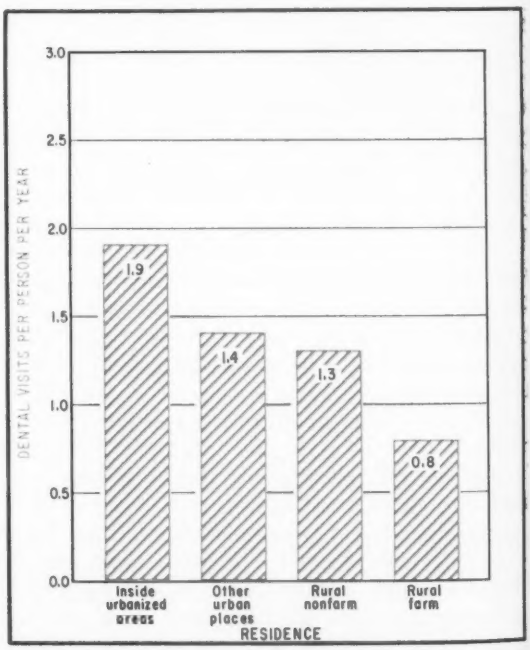


Figure 2. Number of dental visits per person per year by residence.

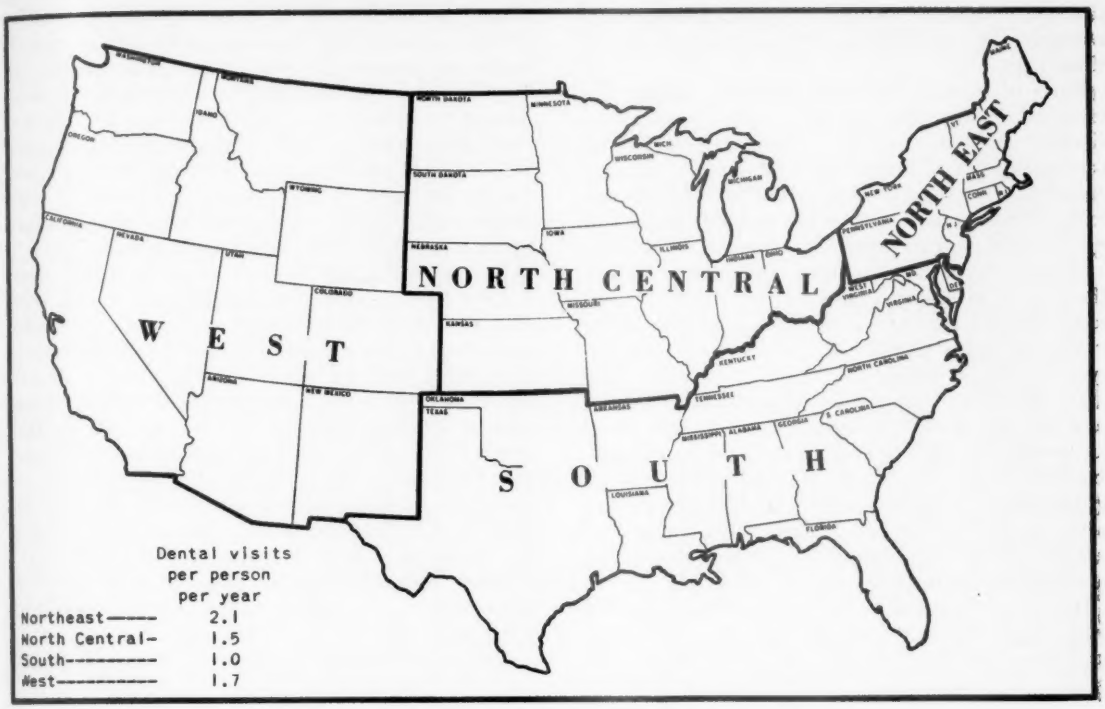


Figure 3. Number of dental visits per person per year by region.

roughly means those living in and around cities of 50,000 or more population, made on the average 1.9 dental visits per year, while those living on farms in rural areas made only 0.8 visits per person per year. Residents of the Northeastern region of the United States, which includes New England and the Middle Atlantic states, visited the dentist 2.1 times per year on the average, while those residing in the South averaged only 1.0 visits.

Source of Data

The information contained in this report was obtained from nationwide household interviews conducted by the U. S. National Health Survey. The survey is continuous, each week covering a random sample of the civilian noninstitutional population of the United States. This report is based on interviews obtained during the period July 1957-June 1959, during which time interviews were conducted in approximately 73,000 households throughout the country and included about 235,000 persons.

Volume of Dental Visits

A total of 516.9 million dental visits were made during the two-year period July 1957-June 1959. This represented an estimate of 258.5 million visits per year, which amounted to an average of 1.5 dental visits per person per year.

Although this rate appears to be fairly consistent with the well-known suggestion to "see your dentist twice a year," it should be kept in mind that the rate is an average based on persons who had visited their dentist during the year as well as those who had not. Since about two thirds of the population fall into this latter group the total number of dental visits during a given year were made by a comparatively small proportion of the population.

Any visit to a dentist's office for treatment or advice was considered to be a dental visit in the survey, even if the service was not provided directly by a dentist himself but by a hygienist working under a dentist's supervision.

Estimates of the total volume of dental visits were obtained from answers to the questions "Last week or the week before did anyone in the family go to a dentist?" and if the answer was "yes," "How many times during the past 2 weeks?" The accumulation of counts of dental visits over two years of continuous interviewing provided the basis for the estimates included here. The aggregates shown in the detailed

tables, however, are annual estimates obtained by averaging the counts of dental visits reported in each of the years.

Rates of dental visits varied greatly among the different demographic groups in the population. Figure 1 shows that in the age range 5-64 years, the average number of dental visits for females was consistently higher than for males. For both groups the peak period for dental visits was around 20 years of age. It is also at this point that the greatest discrepancy between the rates for males and females occurs. The higher rate for females may well reflect additional dental care during pregnancy or possibly a greater emphasis placed on the esthetic results derived from good dental care.

The dental care rates for both males and females were low among children under 5 years of age, when the permanent teeth have not yet erupted, and among persons 65 years of age and older, a large proportion of whom are edentulous. Other dental care data from the survey show that during a one-year period the vast majority of persons in each of these age groups made no dental visits.

Marked differences in the frequency of dental visits occurred among persons living in urban and rural areas (fig. 2). Persons living "inside urbanized areas" (in and around cities having a population of 50,000 or more) had the highest number of dental visits per person, 1.9 per year. Persons living in smaller urban places and "rural-non-farm" persons visited the dentist less frequently, with 1.4 and 1.3 visits per person per year, respectively. Rural-farm persons had the lowest rate of visits, 0.8 visits per person per year. These differences by area of residence, noted in the total population, were consistently present in the various age-sex groups.

By comparing the over-all rates of dental visits for the four regions of the country, it can be seen that persons in the Northeast region averaged more dental visits than persons in any of the other regions. The West had the second highest rate of dental visits, and the North Central region had the third highest. Persons living in the South made, on the average, the least number of dental visits. Their rate was about half of that for the Northeastern region (fig. 3). The regional differences, showing the Northeast having the highest rate of dental visits, the South, the lowest rate, and the West and North Central regions in a middle position, show up quite consistently in the different age-sex segments of the population.

Rates for the four regions have been computed

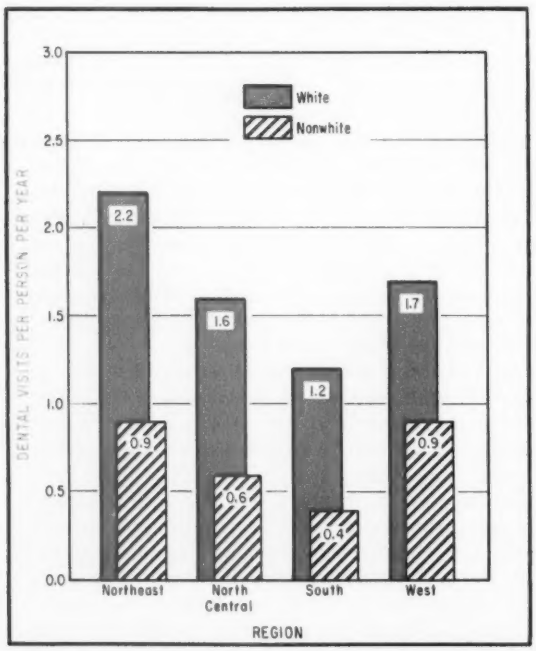


Figure 4. Number of dental visits per person per year by region and race.

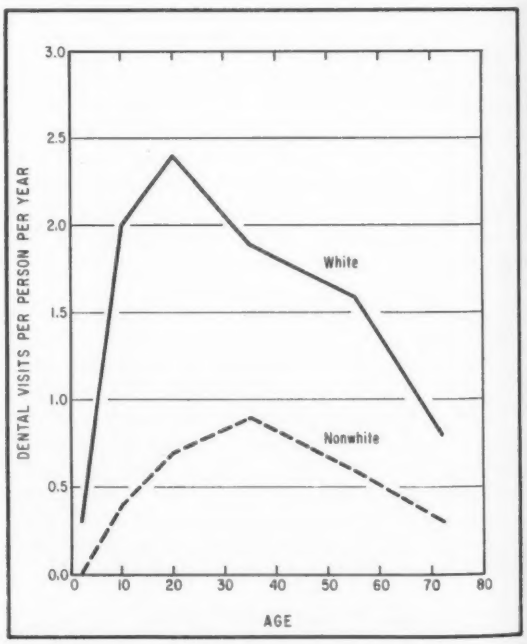


Figure 5. Number of dental visits per person per year by race and age.

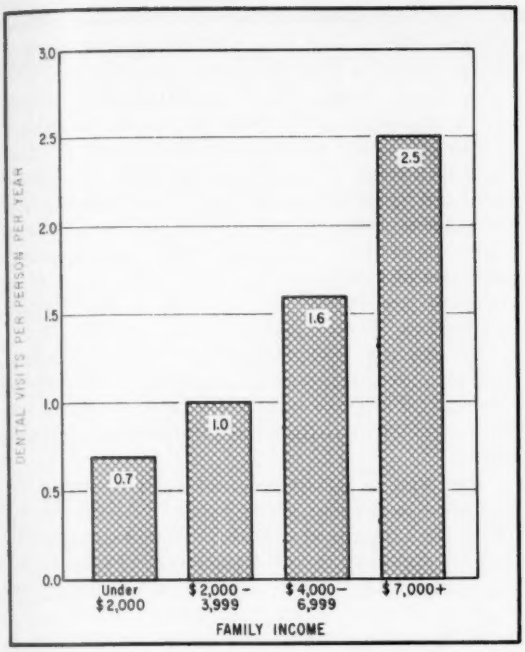


Figure 6. Number of dental visits per person per year by family income.

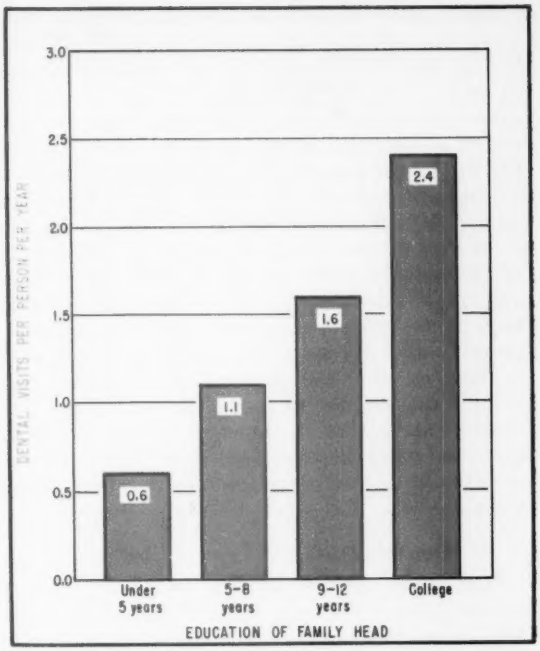


Figure 7. Number of dental visits per person per year by education of family head.

separately for the white and nonwhite subgroups of the population and are presented in figure 4. Note that approximately the same regional pattern appears for both white and nonwhite persons separately, as for all races combined. In each of the four regions, the rates for the nonwhite population were substantially below those for white persons.

In figure 5, on page 12, the rates for the two racial groups are given separately by age. The rate for nonwhite persons was consistently lower than the rate for white persons in each of the age groups. In the 5-14 year age group, for example, white children visited the dentist at an average of 2.0 visits per year, while nonwhite children averaged only 0.4 visits, a rate only one fifth as large. Similar differences occurred in the other age groups.

Family income is one of the socioeconomic variables which has a striking effect on the volume of dental visits reported. For all age groups combined, the dental visit rate increased successively from 0.7 visits per person per year for persons in families with annual incomes under $2,000 to a high of 2.5 visits for those in families with annual incomes of $7,000 or more (see fig. 6 above). Because both family income and rate of dental visits vary with age, it is necessary to examine the relationship between family income and rate of dental visits for separate age groups. From the data, it can be seen that the direct relationship between family income and rate of dental visits occurred within each of the individual age groups shown.

Another socioeconomic variable—the educational attainment of the family head—also bears a direct relationship to the rate of dental visits. Persons in families whose head of family had less than 5 years of formal schooling averaged only one fourth as many dental visits as persons in families whose head of family had completed at least one year of college (fig. 7). The dental visit rates were higher in each successive educational group from "under 5 years of education" to "college."

The direct relationship between rate of dental visits and education of family head existed in each of the age groups as well as for all age groups combined. The difference in rates is most noticeable for children in the 5-14 year age group, where those in families whose head of family had attended college made on the average about six times as many dental visits per person as those in families whose family head had less than 5 years of education.

Not only are family income and education of family head strongly associated with rate of dental visits but the two variables are also closely related to each other. By cross-classifying the two variables

each can be examined in relation to dental visits while the other is held constant. In figure 8 it may be seen that among lower income families, the rate of dental visits was approximately twice as high for those whose family head had 9 or more years of school as for those whose family head had less education. Among higher income families, the ratio between the dental visit rates of the "high" educational and "low" educational groups was 1½ to 1. The results are similar when comparing the rates for the two income groups for persons in "low" educational and "high" educational families separately. Within each of the educational groups, those in higher income families averaged twice as many dental visits as those in lower income families. It may be seen as well that similar relationships exist within the separate age groups. It thus appears that family income and educational attainment of the family head are each in themselves related to the rate of dental visits.

Dental Visits by Type of Service

Data pertaining to the type of service received during dental visits were collected during July 1957-June 1958. Thus, while the material on volume of dental visits is based on two years of interviewing, the material on type of dental service is based on only one year of interviewing.

Approximately 43 percent of all dental visits made during the period July 1957-June 1958 involved work related to fillings, crowns, inlays, and so forth. This was the largest single "type of service" category. Work relating to extractions was carried on in about 17 percent of the visits and teeth cleaning or examination in about 18 percent of the visits. "Straightening" and "gum treatment" were done in only a small proportion of the dental visits, 3 percent and 2 percent, respectively. "Denture work" which includes all types of bridgework as well as the taking of impressions and fitting and repairing of false teeth accounted for about 9 percent of the visits (fig. 9).

In collecting and tabulating the data, a visit was tallied under each type of service performed during the visit. Thus, the sum of the visits by type of service is greater than the total number of dental visits made.

The types of service received during a dental visit varied with the age of the patient. About one half of the dental visits of children 5-14 and young people 15-24 years of age involved some type of work related to fillings. The proportion of visits including this type of service became successively smaller in the older age groups. Approximately one tenth of the visits of children under 15 years of age involved "extractions" as compared with a proportion twice that size for those 15 years of age and over. "Denture

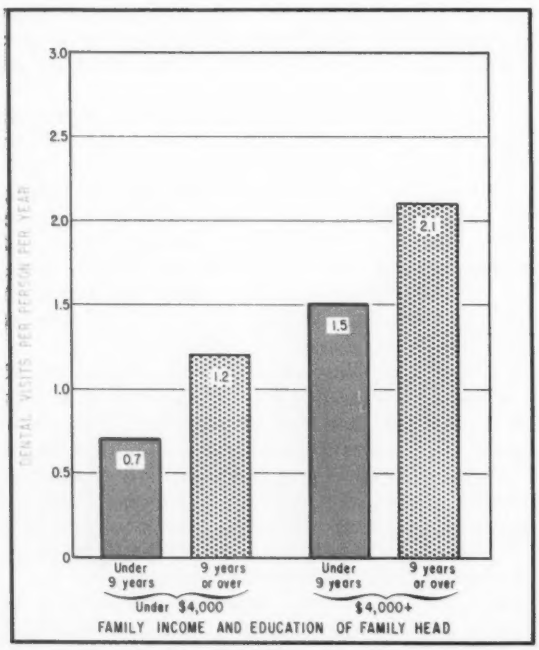


Figure 8. Number of dental visits per person per year by family income and education of family head.

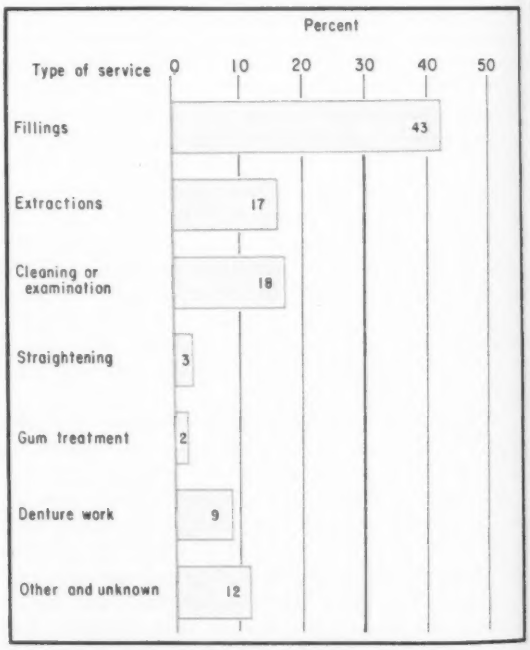


Figure 9. Percent distribution of dental visits by type of service.

Table A. Percent distribution of dental visits and number of dental visits per person per year by type of service according to age: United States, July 1957-June 1958.

Age	Total visits[1]	Type of service				
		Fillings	Extractions	Cleaning or examination	Denture work	Other and unknown
	Percent distribution					
All ages	100	43	17	18	9	17
0-4	100	44	8	31	1	22
5-14	100	50	12	18	1	22
15-24	100	54	19	12	4	14
25-44	100	42	19	19	7	17
45-64	100	32	17	18	19	15
65+	100	17	22	16	34	13
	Number of dental visits per person per year					
All ages	1.6	0.7	0.3	0.3	0.1	0.3
0-4	0.3	0.1	0.0	0.1	0.0	0.1
5-14	1.9	0.9	0.2	0.3	0.0	0.4
15-24	2.3	1.2	0.4	0.3	0.1	0.3
25-44	1.9	0.8	0.4	0.4	0.1	0.3
45-64	1.7	0.5	0.3	0.3	0.3	0.3
65+	0.8	0.1	0.2	0.1	0.3	0.1

[1] The sum of the percentages may add to more than 100 percent because one visit may involve more than one type of service.

work" including bridgework was done during only a small proportion of visits of children and young people, but the proportion of visits involving this type of service increased with age to 34 percent for persons 65 years of age and over. Teeth straightening occurred principally among children (table A.)

The relationships between type of dental service and the various demographic variables were consistent with those found for volume of dental visits. In general, groups that had a low rate of dental visits also had a comparatively high proportion of their dental visits devoted to extractions (table B). For example, males had a higher proportion of their dental visits devoted to extractions than did females; rural-farm persons had a higher proportion of visits involving extractions than did rural-nonfarm persons, who in turn had a higher proportion than urban persons. Although the relationships were not quite as pronounced in the case of proportion of dental visits involving fillings, the tendency was for groups with high rates of dental visits to have a higher proportion of their visits devoted to fillings than was true for groups with low rates of dental visits.

When the types of services rendered are considered from the point of view of number of visits per person per year, a slightly different picture is presented. The number of visits per person per year involving extractions was very stable from group to group, namely either 0.2 or 0.3 visits per person. The rate of visits involving fillings varied greatly from group to group, however, with the groups having a high over-all rate of dental visits also having a high rate of visits for fillings.

Thus it would appear from the figures in table B that the average number of dental visits involving extractions was consistent throughout the different subgroups of the population, while the average number of dental visits involving preventive services varied greatly from group to group. It is this variation in number of visits for preventive services that brings about the differences in the percent distributions noted above.

Since a dental visit involving a particular type of dental service was counted only once under that type of service, no matter how many teeth were involved, the data presented here, naturally, do not tell the complete story. They do, however, give some indication of the type of dental care people in the different demographic groups of the population are receiving.

Table B. Percent distribution of dental visits and number of dental visits per person per year by type of service according to demographic characteristic: United States, July 1957-June 1958.

Characteristic	Percent distribution				Number of dental visits per person per year			
	Total visits[1]	Fillings	Extractions	All other	Total visits[1]	Fillings	Extractions	All other
Total persons	100	43	17	44	1.6	0.7	0.3	0.7
Sex								
Male	100	43	19	43	1.4	0.6	0.3	0.6
Female	100	43	16	44	1.8	0.8	0.3	0.8
Residence								
Urban	100	44	15	45	1.9	0.8	0.3	0.8
Rural nonfarm	100	43	20	41	1.3	0.6	0.3	0.5
Rural farm	100	37	26	40	1.0	0.4	0.3	0.4
Region								
Northeast	100	48	13	44	2.2	1.0	0.3	1.0
North Central	100	46	16	40	1.6	0.7	0.3	0.6
South	100	34	26	44	1.0	0.4	0.3	0.5
West	100	38	15	49	1.8	0.7	0.3	0.9
Race								
White	100	44	16	44	1.7	0.8	0.3	0.8
Nonwhite	100	23	45	33	0.5	0.1	0.2	0.2
Family income								
Under $2,000	100	27	37	37	0.8	0.2	0.3	0.3
$2,000-3,999	100	36	23	45	1.1	0.4	0.2	0.5
$4,000-6,999	100	47	16	40	1.7	0.8	0.3	0.7
$7,000+	100	46	10	49	2.6	1.2	0.3	1.3
Education of family head								
Under 5 years	100	38	32	34	0.8	0.3	0.2	0.3
5-8 years	100	40	24	40	1.2	0.5	0.3	0.5
9-12 years	100	44	17	42	1.7	0.7	0.3	0.7
College	100	46	9	50	2.7	1.2	0.2	1.3
Family income and education of family head								
Under $4,000								
Under 9 years	100	29	35	40	0.7	0.2	0.2	0.3
9 years or over	100	36	22	44	1.3	0.5	0.3	0.6
$4,000+								
Under 9 years	100	46	19	39	1.7	0.8	0.3	0.6
9 years or over	100	46	12	46	2.2	1.0	0.3	1.0

[1] The sum of the percentages may add to more than 100 percent because one visit may involve more than one type of service.

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